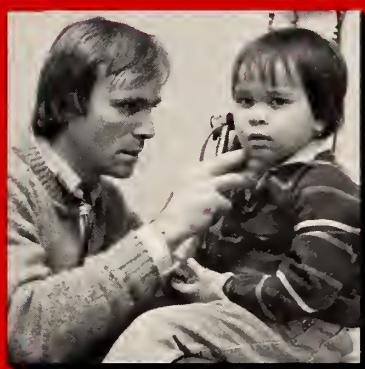
INDIAN HEALTH SERVICE

A Comprehensive Health Care Program for American Indians and Alaska Natives



INDIAN HEALTH SERVICE

A Comprehensive Health Care Program for American Indians and Alaska Natives

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Indian Health Service

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Foreword

Comprehensive health care—preventive, curative, rehabilitative and environmental—for approximately 1 million eligible American Indians and Alaska Natives is the responsibility of the Indian Health Service.

Since 1955, this Bureau of the U.S. Public Health Service has made notable progress in raising the health status of these people to the highest possible level. In striving to carry out this goal, the dedicated staff has three main objectives:

1.) Deliver the highest quality health services possible;
2.) Assist tribes and Native corporations to develop their capacity to staff and manage health programs; and
3.) Act as the Federal advocate in health related matters.

The provision of health care is accomplished through a Federal-Tribal partnership with a common aim. We are pleased to report that the health status gap between American Indians and Alaska Natives and the rest of the Nation continues to narrow.

To maintain and increase both public and governmental support, it is essential that there be greater understanding of the health care afforded American Indians and Alaska Natives. It is to this purpose that this publication is dedicated.

Everett R. Rhoades, M.D.
Assistant Surgeon General, USPHS
Director, Indian Health Service

Introduction

American Indians and Alaska Natives, like other citizens, benefit from public health programs intended to improve health care for all Americans. Members of federally recognized Indian tribes and Alaska Natives are eligible for health services provided by the Indian Health Service (IHS), an organization of the U.S. Public Health Service (USPHS), of the Health Resources and Services Administration. The Federal Government's responsibility for the approximately 1 million American Indians and Alaska Natives has a long history originating from treaties dating from 1784, and further established through laws enacted by the Congress.

Members of the more than 500 federally recognized Indian tribes and groups live primarily on Federal Indian reservations and in small rural communities. The majority of the 32 States in which these reservations and communities are located are in the western half of the Nation. The Alaska Natives, a term embracing people of the Athabaskan, Tsimpsian, Tlingit and Haida Indian tribes and the Eskimo and Aleut peoples, live throughout Alaska, predominantly in remote, isolated villages.

The Indian and Alaska Native people have maintained much of their traditional culture. Some, especially the older people, speak little or no English. They are among the most impoverished of the U.S. population, and often live without life-serving necessities such as good nutrition, safe water supplies, adequate waste disposal facilities, and other sanitary amenities. Many reservations and Indian communities are located in isolated, rugged areas where climatic conditions are often harsh. These situations, coupled with periodically impassable roads, make transportation difficult. In many areas of Alaska, roads are nonexistent requiring the ill or injured to be airlifted to health care facilities.

Numerous health-related problems exist in high proportions among Indians and Alaska Natives. Some of the most serious are injuries, alcoholism, mental health problems, otitis media (middle ear diseases), nutritional deficiencies, and poor dental health. Other major health concerns are maternal and child health needs, unhealthy environmental conditions, and problems associated with aging.

Substantial progress has been made, however, in combating health problems, especially, infectious diseases. In 1954-56, for example, the mortality rate for tuberculosis was 55.1 per 100,000 population. By 1981-83, the rate dropped to 2.3 representing a decrease of 96 percent. Reductions also have occurred in mortality rates for other diseases. The mortality rate among infants for the 3-year period 1981-1983 is down 82 percent from 1954-56, and pneumonia and influenza has been reduced by 82 percent for the same period. The mortality rate for gastrointestinal diseases has declined by 93 percent since 1954-56.

But much remains to be done before the Indian and Alaska Native people attain health parity with other U.S. citizens. In recognition of this fact, and of the desire of the Indian and Alaska Native people to have greater control over their own destiny, the Congress has passed two landmark laws.

Public Law (P.L.) 93-638, the Indian Self-Determination and Education Assistance Act was enacted in 1975. It relates to the activities of the Indian Health Service and the Department of Interior's Bureau of Indian Affairs. This legislation strengthens and enhances the IHS long-standing policy of giving Indian people maximum opportunity to become meaningfully involved in the programs serving them. Specifically, the law gives the Indian tribes and Alaska Native groups the option of managing and operating health care programs in their communities. It also authorizes assistance, if needed, for any tribe or group wanting to develop or improve the capabilities to take advantage of this option.

The Indian Health Care Improvement Act, P.L. 94-437, passed in 1976, and its amendment, P.L. 96-537 passed in 1980, were intended to elevate the health status of Indians and Alaska Natives to a level equal to that of the general population through a 7-year program of authorized higher resource levels in the IHS budget. Appropriated resources were used to expand health services, build and renovate medical facilities, and step up the construction of safe drinking water and sanitary waste disposal facilities. Also established by law were programs designed to increase the number of Indian health professionals, and to improve health care access for the more than 650,000 Indians living in urban areas.

Mission and Organization

Physicians qualified through special training care for the newborn with complications . . .

The IHS mission is to ensure the availability of a comprehensive health care delivery system that will provide Indians and Alaska Natives opportunities for maximum involvement in defining and meeting their own health needs.

To achieve this, the IHS has three main objectives:

1. Deliver the highest quality comprehensive health care services possible, including hospital and ambulatory medical care, preventive and rehabilitative services, and community and environmental health programs, among them the construction of safe water supplies and waste disposal.
2. Assist tribes and Native corporations to develop the capacity to staff and manage health programs, and provide them the opportunity to assume operational authority for programs.
3. Act as the Indians' and Alaska Natives' Federal advocate in health related matters.

In carrying out its mission, the IHS interacts with other Federal and State agencies and public and private institutions in developing ways to deliver health services,

stimulate consumer participation, and apply resources.

Administration

The IHS headquarters offices are in Rockville, Maryland, a Washington D.C. suburb. The headquarters staff coordinates and monitors area and field activities, prepares statistical information, provides support for policy development, and program formulation. Planning, implementation and evaluation, operational management, community development, and tribal affairs applicable to the total Indian health program are also managed from these offices.

Area Administration

The IHS is divided administratively into eleven Area Offices. Each Area Office is responsible for operating the IHS program within a designated geographical area. The responsibilities of these administrative offices include budget; operation; personnel and property management; program planning, implementation, and evaluation; tribal affairs; community development; statistical information; grants and contracts management; and environmental health program direction. Staff of Area Office health services branches in nursing, dental and other disciplines, work with corresponding staff at the service unit level.

Delivery of health services at the local level is the responsibility of an IHS Service Unit, an administrative subdivision of an Area. There are 125 Service Units in the IHS; each covers a defined geographic area such as an Indian reservation or population concentration (Alaska, Nevada, and Oklahoma are statewide service areas without reservations).

. . . and continue to provide comprehensive health care to those who are aged.

A few Service Units serve a number of small reservations, and conversely some large reservations, such as the Navajo which covers 25,516 square miles, and in fiscal year 1986 had a service population of 171,000, are served by several Service Units. These basic health service delivery components contain a hospital or health center.

Alaska Area

In Alaska, the 13 Tribal health corporations operate a wide variety of health service programs in conjunction with the Service Units direct services. The corporations' administrative direction is provided by a central staff with most programs contracted as recurring such as Hepatitus B. screening, Fetal Alcoholism Syndrome, Orientation Public Health Nursing, Alcoholism, Emergency Medical Services, Community Health Services, and itinerant dental and optometry services. The daily medical services such as basic examinations, gathering samples and dispensing of certain pharmaceuticals are usually accomplished at the village clinics. The village-built clinic programs are operated and staffed by Community Health Aides or Physician Assistants employed by the health corporations. The total number of village-built clinics is 142.

California Area

In California, health care is provided to Indians entirely through contracts with non-profit Indian and tribal organizations, and therefore, the operation of the California Office is somewhat different from the other IHS Areas. There are no IHS-operated hospitals or health centers. Twenty rural health programs funded by the IHS provide

Community health nurses provide a wide variety of services and work closely with other health personnel.

care at 19 health centers and 21 health stations.

All, except two, of the health programs also receive funding from the State and therefore must comply with additional regulations. Requirements include the use of third-party payers (Medicare, Medi-Cal, and private health care insurance), and the provision of services to non-Indians.

The California Area Office also adminsters contracts for urban health care centers. Alcoholism services in California and Hawaii are contracted with Indian organizations.

Research and Training

The Office of Health Program Development (OHPD), located near Tuscon, Arizona, on the San Xavier portion of the Tohono O'Odham reservation, is responsible for developing new and improved methods of delivery of health services.

Unlike most research and development operations, the office also has line responsibility for delivery of health services to nearby Indians who are active participants and contributors to improved health delivery program designs often applied throughout the IHS. The office provides area and service unit functions as well as direct services in remote, rural and urban environments, hence the staff is familiar with the range of operational problems and opportunities encountered in the Indian health delivery system.

The developments of the office have ranged from paper protocols to assist tribal outreach workers to adaptations of space technology to remote village health care. Programs to develop and train tribal Community Health Representatives (CHR) and Community Health Medics (CHM) originated with this office.

The IHS, to improve its effectiveness and efficiency, is developing a comprehensive automated information system, the Resource and Patient Management System (RPMS). OHPD is in the forefront of developing the ambulatory care information system as part of RPMS as well as testing and/or developing other associated information system modules such as laboratory, pharmacy and patient registration. This emphasis on ambulatory and outreach sub-systems has existed since the inception of the office. Techniques developed for analysis and improvement of ambulatory care and outreach operations have been widely adopted throughout IHS, the U.S. Army Medical Command and the ministries of health of the Arab Republic of Egypt and Panama.

Direct assignments from the IHS director include resource allocation methodology development, analysis and plans for operational improvement of major management issues such as contract health services and evaluation issues ranging from urban programs through medical centers to P.L. 93-638 programs.

OHPD works with other IHS and tribal personnel throughout the Indian Health program to coordinate the implementation of innovative, effective and efficient program designs resulting from research and development efforts.

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A Comprehensive Approach

The IHS operates a comprehensive health services program designed to meet the needs of the Indian and Alaska Native people. The program is planned and carried out in cooperation with Indian organizations at the national, regional and local levels by Federal, State and local agencies, educational institutions, professional societies, voluntary health associations, and others.

To the extent resources permit, Indians and Alaska Natives served by the IHS receive a full range of preventive, primary medical (hospital and ambulatory care), community health, alcoholism programs, and rehabilitative services. Secondary medical, highly specialized medical services, and rehabilitative care is provided by IHS staff, or through contract by non-IHS providers. Preventive health activities represent a prime focus of the IHS comprehensive health strategy. Emphasis is placed on stimulating and enhancing Indian involvement. This includes expanding Indian manpower within IHS in administrative and health service delivery professions, thereby strengthening Indian influence in IHS policy formulation, and developing and improving tribes' and Native groups' abilities to manage and operate health programs.

Primary Medical Services

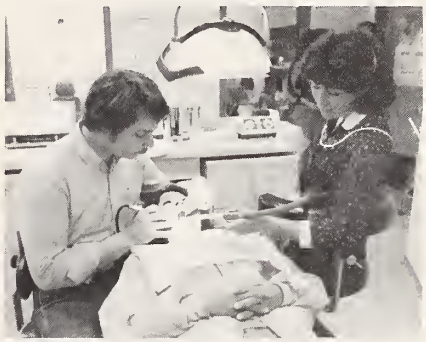
The IHS program is community-oriented. The foundation of the program is a system of inpatient and ambulatory care facilities which the IHS operates on Indian reservations and in Indian and Alaska Native communities. The 46 IHS hospitals (as of October 1, 1985) range in size from 11 to 170 beds. Three of these—in Phoenix, Arizona; Gallup, New Mexico; and Anchorage, Alaska—also serve as referral, training and research centers. Within this network of health care facilities are 72 health centers, 12 school health centers, and approximately 250 health stations and satellite field health clinics.

In locations where the IHS does not have its own facilities, or is not equipped to provide a particular service, it uses contract providers such as local hospitals, State and local health agencies, tribal health institutions, and individual health care providers. Services purchased through contract include primary, secondary, and rehabilitative care, specialized diagnostic and therapeutic services, and public health and community outreach activities.

Tribally contracted health programs are conducted primarily under authority of the Indian Self-Determination and Education Assistance Act, P.L. 93-638. Enacted in 1975, this law includes the authority for Indian tribes, on their own initiative, to contract to manage health programs or portions of programs currently operated by the IHS.

Under authority of P.L. 93-638 contracts have been negotiated with tribes to operate 5 hospitals and approximately 300 health centers and clinics. Many tribes operate a portion of a health program such as alcoholism, mental health, community health, and environmental heatlh services. As part of the congressional intent and spirit of this law, it is essential that the IHS provide technical assistance and other support to help tribes succeed in their Indian self-determination efforts.

IHS direct and contract tribal services presently account for approximately 4,400,000 out patient visits and about 109,000 hospital admissions annually. The IHS Service Unit clinical staff includes physicians, dentists, nurses, pharmacists, therapists, dietitians, laboratory and radiology technicians, and medical and dental assistants. Community health medics (IHS-trained physician assistants) nurse practitioners and nurse midwives complete this clinical health care team, and many serve in remote ambulatory care facilities. The clinical staff is supported by health records, engineering, housekeeping, maintenance, dietetic service, supply, and other administrative and clinical personnel.



Four-handed dental practice increases the efficiency at IHS hospitals and health centers. Some areas also are served by mobile dental clinics.

Emergency Medical Services

Emergency Medical Services in Indian communities is a tiered approach designed to assist persons who find themselves in need of medical care due to some emergency (most frequently involving trauma).

The First Responder concept is the key to the System. This is a trained individual (CHR or Police) who can respond within 15 minutes and communicate (via radio) to the next level of care.

Due to remote, rural locations, ambulance response (ground or air) may take an hour. Tribes have taken the primary initiative in providing ambulance service. Some 75

tribes operate 150 vehicles with over 500 trained EMTs.

Indian Health Service/Tribes operate emergency rooms with trained medical/nursing personnel throughout IHS. These serve as initial receiving facilities. Referrals are made to the most appropriate tertiary facility for definitive care.

Accidental death rates have declined in the past ten years from 150/100,000 to 75/100,000.

Preventive Health Services

Preventive health services are provided by clinical staff at IHS and tribal facilities, and by community health personnel, forming integrated health teams which work within the Indian community. Services include pre-natal, post-natal and well baby care, family planning, dental health, nutrition, immunizations, environmental health activities, and health education. Among the programs involved in the integrated approach to preventive health are community health nursing, dental health, medical social work, environmental health and health education.

Community Health Nursing

The primary focus of the IHS public health nursing program is the prevention of illness and the promotion and maintenance of health. Community health nurses are involved in planning and coordinating community programs and services; determining health needs for the individual, the family and the community; assessing health status; implementing health planning; evaluating health practices; and providing primary health care. In these endeavors the community health nurse works in close cooperation with other health personnel, especially community health representatives, maternal and child health aides and other indigenous auxiliary workers.

Community health nurses make house calls—in this instance by way of a 4-wheel-drive vehicle over muddy, deep rutted roads that otherwise would have been impassable.

Community health nurses help prevent complications of pregnancy and improve the general health status of expectant Indian mothers and their infants by promoting early care in pregnancy.

Early visits to the newborn in their homes and the giving of special attention to infants in high-risk families have proven beneficial in reducing morbidity and mortality. IHS community health nurses also investigate the causes of communicable diseases through home visits; strengthen health teaching in the home; the community, and the clinical setting; provide counseling and guidance in health and family living to teenagers and young adults; and immunize infants and children against infectious diseases.

Dental Health

Dental services are carried out in 243 locations. These are at IHS hospitals, health centers and other fixed facilities as well as at 167 field and in 26 mobile dental sites. In some locations, particularly in Alaska, itinerant IHS dental teams with portable equipment visit isolated villages—often by aircraft or boat.

Primary dental program objectives are to reduce tooth mortality and decrease the incidence of dental caries and the severity of periodontal disease. Special attention by IHS practitioners is given to preventive activities which have a favorable impact on these goals.

The dental program places priority on providing preventative and corrective dental care that will result in maximum oral health for the greatest number of people. Emphasis is placed on effective measures to prevent disease and decrease tooth loss. Effective caries preventive measures, such as water fluoridation, that provide benefits, at the community level are encouraged. To ensure that fluoridation equipment is installed in Indian community water supply systems functions efficiently and safely, dental health staff work closely with IHS environmental health program personnel and tribal workers. The use of tooth sealants is widely practiced and health promotion and disease prevention efforts are also aimed at reducing baby bottle tooth decay and the use of smokeless tobacco.

Clinical services are provided to all ages, with emphasis on early treatment and patient education to limit the severity of periodontal disease and caries. Special population

groups including children, the home-bound, elderly and handicapped all of which present special circumstances. These are addressed by IHS dental professionals in coordination with environmental health workers, public health nurses, nutritionists and pharmacists.

Medical Social Work

The IHS medical social work program focuses on the social and emotional problems that may interfere with medical treatment. Working closely with physicians and nurses, the professional social workers and para-professional associates deal with patient-related problems such as fear of treatment procedures, adjusting to limitations imposed by medical conditions, and worry about child care or loss of income while being hospitalized. Their clinical assessments and interventions contribute to treatment plans and continuity of care.

Another part of the medical social work program is the liaison function with community agencies. Often, problems identified in the medical setting require outside assistance such as in dealing with suspected child abuse or nursing home placements. Knowledge of alternate resources and community contracts help social workers get supplemental services to patients and their families.

Environmental Health

Environmental health services form an especially important part of the IHS preventive health initiative because they attack the broad spectrum of conditions in Indian homes and communities which contribute so dramatically to high morbidity and mortality among the Indian people. The environment, which includes the home, community and work place, as well as the surroundings, is recognized as a vital factor in the overall health and well-being of the people.

The IHS environmental health program encompasses the provision of a broad and comprehensive array of services. The staff is extensively involved in efforts to enhance the availability and quality of water used for domestic purposes in Indian homes and in the provision of safe and sanitary solid and liquid waste disposal. Related activities include environmental planning, occupational health and safety, community injury control, air, water and solid waste pollution control, and institutional environmental health in reservation areas. Staff members include environmental engineers, sanitarians, environmental health and engineering technicians, and community injury control coordinators.

Typically, environmental health program activities include:

- Identify and recommend remedies for the causes of injury among the Indian people.
- Continuous evaluation of changing environmental conditions and plan with tribal officials for the development of comprehensive health programs.
- Participation in the investigation of communicable disease outbreaks and initiating corrective environmental control measures.
- Perform community and individual premise evaluations to determine and eliminate environmental health deficiencies.
- Provide technical assistance and training to Indian communities in the operation and maintenance of water supply and waste disposal facilities.
- Evaluate institutional facilities operated by the Bureau of Indian Affairs and the Public Health Service. Make recommendations to the operators so that they may maintain a healthful environment.
- Assist tribes in the development and adoption of sanitary ordinances and codes.
- Work to alleviate crowded substandard housing, unsafe water supplies and inadequate waste disposal facilities. The basic legislation for attacking the two latter conditions is Public Law 80-121, the Indian Sanitation Facilities Act. Since the law was passed in 1959, the IHS has through fiscal year 1985 initiated more than 3,800 projects to provide sanitation facilities for Indian homes and communities. Upon completion of all of these projects 149,000 Indian residences (89,000 new or improved houses and 60,000 existing ones) will have received running water and a means for safe waste disposal. Much of this work has been done under cooperative agreements with the Bureau of Indian Affairs, the Department of Housing and Urban Development and various Indian housing authorities.

Other projects initiated under P.L. 86-121 include engineering surveys, emergency construction, and technical assistance and training for tribal employees in the use, care and maintenance of constructed facilities. The Indian people have participated in P.L. 86-121 projects by contributing labor, material and funds.

Health Education

The IHS health education program relating to specific diseases as well as health and safety hazards faced by Indians and Alaska Natives is designed to assist them to as-

sume greater individual, family, and community responsibilities through involvement and participation. The program attempts to increase the understanding of the nature of disease and how it can be reduced, encourage more discriminating use of health services, develop Indian leadership in assumption of responsibility for health matters, and increase involvement of other agencies that have the potential for contributing to the improvement of the health of this population.

Special Health Concerns

Certain health-related problems are of special concern to the IHS and tribal leaders because of their impact on the Indian community. Among these are alcoholism, depression and other mental health concerns, diabetes, accidents, maternal and child health, nutrition, otitis media and aging. The strategy to deal with these difficult problems is centered on comprehensive preventive measures and extensive community action and control.

Alcoholism

Alcoholism and alcohol abuse continue to be leading causes of health problems among Native Americans. It is widely held that 95% of American Indians and Alaska Natives are affected either directly or indirectly by a family member's abuse of alcohol. This is confirmed by data obtained by IHS from the National Center of Health Statistics, DHHS, which shows that four of the top ten causes of death among Indian people may be directly related to alcohol abuse. The four causes are *accidents, cirrhosis of the liver, suicide, and homicide.* Finally, according to information disseminated by the National Clearinghouse on Alcohol Information, American Indians have the highest reported frequency of problems associated with drinking when considered with other special groups. Alcoholism has been responsible for the social disorganization that has resulted in broken homes, violence, arrests, auto accidents, unemployment, and wasting of human lives and human potential. In addition to social devastation, alcoholism causes or contributes to an array of physical disabilities that must be treated by IHS and which drain medical care resources that are needed to address other pressing health problems.

Title II of Public Law 94-437 authorized the transfer of Indian alcoholism programs from the administrative jurisdiction of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) to the IHS. To date all Indian alcoholism programs funded by the NIAAA (180) have been transferred to the IHS. The transition was completed at the beginning of FY 1983. Presently, the IHS is funding 200 American Indian/Alaska Native alcoholism programs to Indian reservations and urban communities. The IHS has established as one of its major initiatives a plan of action that will require collaborative efforts with Federal entities, Tribal Communities and their respective leaders in the development of an effective and permanent alcoholism/substance abuse prevention program.

The IHS funded alcoholism program locations are as follows;

Bemidji Area. Chicago, IL, Baraga, MI; Brimley, MI; Dearborn, MI; Mount Pleasant, MI; Suttons Bay, MI; Watersmeet, MI; Wilson, MI; Cass Lake, MN; Duluth, MN; Onamia, MN; Red Lake, MN; St. Paul, MN; White Earth, MN; Bayfield, WI; Bowler, WI; Crandon, WI; Haywood, WI; Keshena, WI; Lac Du Flambeau, WI; Milwaukee, WI; Odanah, WI; Oneida, WI; Spooner, WI; Tomah, WI; Webster, WI.

Billings Area: Browning, MT; Butte, MT; Box Elder, MT; Crow Agency, MT; Harlem, MT; Lame Deer, MT; Missoula, MT; Poplar, MT; Ronan, MT; Ethere, WY; Sheridan, WY.

California Area: Alturas, CA; Anderson, CA; Auborn, CA; Banning, CA; Bishop, CA; Clovis, CA; Compton, CA; El Cajon, CA: Eureka, CA; Fresno, CA; Happy Camp, CA; Hoopa, CA; Independence, CA; Los Angeles, CA; Oakland, CA; Oroville, CA; Porterville, CA; Sacramento, CA; San Francisco, CA; San Jose, CA; Santa Rosa, CA; Stockton, CA; Susanville, CA; Tuolumne, CA; Uklah, CA; Honolulu, HI.

Navajo Area: Chinle, AZ; Fort Defiance, AZ; Ganado, AZ; Kayenta, AZ; Lupton, AZ; Page, AZ; Tuba City, AZ; Window Rock, AZ; Winslow, AZ; Crownpoint, NM; Gallup, NM; Shiprock, NM.

Oklahoma City Area: Lawrence, KS; Topeka, KS; Kansas City, MO; Ada, OK; Concho, OK; Durant, OK; Lawton, OK; Okmulgee, OK; Pawhuska, OK; Pawnee, OK; Ponca City, OK; Shawnee, OK; Tahlequah, OK; Tonkawa, OK; Tulsa, OK; White Eagle, OK; Grand Prairie, TX.

Aberdeen Area: Sergeant Bluff, IA; Tama, NB; Macy, NB; Niobrara, NB; Omaha, NB; Winnebago, NB; Belcourt, ND; Bismarck, ND; Fort Totten, ND; Fort Yates, ND; New Town, ND; Trenton, ND; Eagle Butte, SD; Flandreau, SD; Fort Thompson, SD; Kyle, SD; Lower Brule, SD; Misson, SD; Pine Ridge,

SD; Rapid City, SD; Sisseton, SD; Yankton, SD.

Alaska Area: Anchorage, AK; Barrow, AK; Bethel, AK; Copper Center, AK; Dillingham, AK; Fairbanks, AK; Juneau, AK; Kotzebue, AK; Metlakatia, AK; Seldovia, AK.

Albuquerque Area: Denver, CO; Ignacio, CO; Towaoc, CO; Acomita, NM; Albuquerque, NM; Bernalillo, NM: Dulce, NM; Laguna, NM; Mescalero, NM; Pine Hill, NM; San Felipe Pueblo, NM; San Juan Pueblo, NM; Santo Domingo Pueblo, NM; Zuni, NM.

Phoenix Area: Camp Verde, AZ; Flagstaff, AZ; Fountain Hills, AZ; Gila Bend, AZ; Kykotsmovi, AZ; Parker AZ; Peach Springs, AZ; Prescott, AZ; Sacaton, AZ; San Carlos, AZ; Scottsdale, AZ; Somerton, AZ; Supai, AZ; Whiteriver, AZ; Yuma, AZ; Needles, CA; Riverside, CA; Duckwater, NV; Elko, NV; Ely, NV; Gardnerville, NV; Nixon, NV; Owyhee, NV; Reno, NV; Yerlington, NV; Cedar City, UT; Salt Lake City, UT.

Portland Area: Ft Hall, ID; Lapwai, ID; Plummer, ID; Foster, OR; Klamath Falls, OR; Grand Ronde, OR; Portland, OR; Pendleton, OR; Salem, OR; Siletz, OR; Warm Springs, OR; Arlington, WA; Auburn, WA; Bellingham, WA; Deming, WA; Forks, WA; La Conner, WA; La Push, WA; Marysville, WA; Neah Bay, WA; Nespelem, WA; Oakville, WA; Olympia, WA; Port Angeles, WA; Seattle, WA; Sedro Wooley, WA; Shelton, WA; Sumner, WA; Suquamish, WA; Tacoma, WA; Taholah, WA; Toppenish, WA; Usk, WA; Wellpinit, WA.

Office of Health Program Development (OHPD): Sells, AZ; Tucson, AZ.

Mental Health

As the Indian and Alaska Native people increasingly have been caught in the conflict between their traditional cultures and the demands of modern society, mental health problems have increased. The seriousness is demonstrated by their 1983 age-adjusted suicide rate which is 1.3 times as high as that of the U.S. population, and by their homicide rate which is 1.9 times as high.

Emotional problems and behavior disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social structure. There is an increasing need for mental health involvement in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

Programs being developed by the IHS are aimed at helping the Indian person overcome cultural and linguistic barriers. Before the initiation of these programs Indian people in need of care often were referred to psychiatrists and other professionals not well acquainted with the realities of Indian life. The resulting encounters often were confusing and discouraging to both patient and psychiatrist.

The IHS mental health effort incorporates two essential requirements—a continuing effort to understand Indian life, ideas and language; and extensive Indian involvement in the program.

Diabetes

Diabetes has become a major health problem for Indians in recent years. The complications of diabetes such as blindness, kidney failure and amputation are afflicting persons with long standing diabetes. During the 1981-83 time period diabetes was the fifth leading cause of death among Indian and Alaska Native people 45 years of age or older. In FY 1985 diabetes was the second leading cause of adult outpatient visits to IHS facilities.

Programs are being developed throughout IHS to help the patient understand diabetes and care for himself. Diabetes care must be adapted for the cultural and linguistic needs of patients. The model diabetes program has served as a focus for such activities.

Accidents/Injuries

The second leading cause of death among Indians and Alaska Natives is accidents. During the 3-year period 1981-83, of the 19,237 Indian and Alaska Native deaths which occurred in the 32 States in which IHS had responsibilities 3,324 deaths (17.3 percent) were due to accidents.

The 1983 age-adjusted death rate for accidents among Indians was 2.3 times that for all U.S. races, and the comparable ratio for Indian motor vehicle accident death rates for that year compared to that for all U.S. was 2.4 times as high.

Accidental injuries and poisonings are the second leading causes for hospitalization for general medical and surgical patients in IHS and contract hospitals. 11,369 discharges and 55,057 hospitals days were attributed to injuries and poisonings in FY 1985. To help combat this problem, IHS environmental health staff members are working with other health disciplines and tribes to develop community injury prevention and control teams to train and offer guidance relative to home and community safety. Many tribes have set up injury control programs in which specially trained community health representatives


PORTLAND AREA
Portland
BILLINGS AREA
Billings
ABERDEEN AREA
Aberdeen
BEMIDJI AREA
Bemidji
IHS
Headquarters
Rockville, MD
NASHVILLE AREA
Nashville
CALIFORNIA AREA
Sacramento
PHOENIX AREA
Phoenix
ALBUQUERQUE AREA
Albuquerque
OKLAHOMA CITY AREA
Oklahoma City
Tucson
Office of Health Program Development
ALASKA AREA
Anchorage
NAVAJO AREA
Window Rock
Symbol Explanation
Headquarters
Headquarters, West
Area/Program Office
Hospital
Tribally Operated Hospital
Health Center
Tribally Operated Health Center
Urban Indian Health Program
Rural-Tribal Health Program
Environmental Health Field Office
School Health Center
Regional Tribal Health Corporation

MAJOR HEALTH FACILITIES FOR INDIANS AND ALASKA NATIVES

INDIAN HEALTH SERVICE ADMINISTRATIVE OFFICES

✪ **HEADQUARTERS**
Rockville, Maryland

★ **Headquarters, West**
Albuquerque, New Mexico

Headquarters, OHPD
Tucson, Arizona

✻ **AREA OFFICES**

ABERDEEN AREA
Aberdeen, South Dakota

ALASKA AREA
Anchorage, Alaska

ALBUQUERQUE AREA
Albuquerque, New Mexico

BEMIDJI AREA
Bemidji, Minnesota

BILLINGS AREA
Billings, Montana

CALIFORNIA AREA
Sacramento, California

NASHVILLE AREA
Nashville, Tennessee

NAVAJO AREA
Window Rock, Arizona

OKLAHOMA CITY AREA
Oklahoma City, Oklahoma

PHOENIX AREA
Phoenix, Arizona

PORTLAND AREA
Portland, Oregon

ABERDEEN AREA

▲ **HOSPITALS**
NEBRASKA
1 Winnebago
NORTH DAKOTA
2 Belcourt
3 Fort Yates
SOUTH DAKOTA
4 Eagle Butte
5 Pine Ridge
6 Rapid City
7 Rosebud
8 Sisseton
9 Wagner

● **HEALTH CENTERS**
NORTH DAKOTA
10 Fort Totten
11 New Town (Minne-Tohe)
SOUTH DAKOTA
12 Fort Thompson
13 Kyle
14 Lower Brule
15 McLaughlin
16 Wanblee

○ **Tribally operated**
IOWA
17 Tama
NEBRASKA
18 Macy
19 Santee
NORTH DAKOTA
20 Trenton-Williston

□ **SCHOOL HEALTH CENTERS**
NORTH DAKOTA
21 Wahpeton
SOUTH DAKOTA
22 Flandreau
23 Pierre

■ **ENVIRONMENTAL HEALTH FIELD OFFICES**
IOWA
24 Sioux City
NORTH DAKOTA
25 Minot
SOUTH DAKOTA
26 Martin
27 Mobridge
28 Pierre

ALASKA AREA

▲ **HOSPITALS**
ALASKA
1 Anchorage
2 Barrow
3 Bethel
4 Kotzebue
5 Dillingham

△ **Tribally Operated**
6 Mt. Edgecumbe
7 Nome

● **HEALTH CENTERS**
ALASKA
8 Fort Yukon
9 Ketchikan
10 Metlakatla
11 St. George
12 St. Paul

○ **Tribally Operated**
13 Fairbanks
14 Juneau
15 Tanana

☆ *REGIONAL TRIBAL HEALTH CORPORATIONS*
16 Tanana Chiefs Health Corp.
17 Southcentral Foundation
18 EEDA Consortium of Tribes
19 North Pacific Rim
20 Copper River Native Assoc.
21 Kodiak Area Native Assoc.
22 Yukon-Kuskokwim Health Corp.
23 Norton Sound Health Corp.
24 Bristol Bay Native Assoc.
25 Maniilaq Association
26 North Slope Borough
27 Southeast Area Regional Health Corp.
28 Aleutian Pribilof Islands Assoc.

ALBUQUERQUE AREA

▲ **HOSPITALS**
NEW MEXICO
1 Albuquerque
2 Mescalero
3 Acoma-Canoncita-Laguna
4 Santa Fe
5 Zuni

● **HEALTH CENTERS**
COLORADO
6 Ignacio
7 Towaoc
NEW MEXICO
8 Canoncito
9 Dulce
10 Isleta
11 Jemez
12 Laguna
13 Santa Clara (Espanola)
14 Taos

○ **Tribally Operated**
NEW MEXICO
15 Alamo
16 Magdalena
17 Ramah (Pine Hill)

BEMIDJI AREA

▲ **HOSPITALS**
MINNESOTA
1 Cass Lake
2 Red Lake

● **HEALTH CENTERS**
MINNESOTA
3 White Earth

○ **Tribally Operated**
4 Cloquet
5 Grand Portage
6 Granite Falls
7 Morton
8 Nett Lake
9 Prior Lake
10 Vineland
11 Welch
MICHIGAN
12 Kincheloe

○ **Tribally Operated**
13 Baraga
14 Brimley
15 Mount Pleasant
16 Suttons Bay
17 Watersmeet
18 Wilson
WISCONSIN

○ **Tribally Operated**
19 Bayfield
20 Bowler
21 Crandon
22 Hayward
23 Keshena
24 Lac du Flambeau
25 Ddanah
26 Oneida
27 Tomah
28 Webster

■ **ENVIRONMENTAL HEALTH FIELD STATIONS**
WISCONSIN
29 Ashland
30 Eau Claire
31 Rhinelander

BILLINGS AREA

▲ **HOSPITALS**
MONTANA
1 Browning
2 Crow Agency
3 Harlem

● **HEALTH CENTERS**
MONTANA
4 Box Elder
5 Lame Deer
6 Lodge Grass
7 Polson
8 Poplar
9 St. Ignatius
10 Wolf Point
WYOMING
11 Arapahoe
12 Fort Washakie

CALIFORNIA AREA

◊ **RURAL-TRIBAL HEALTH PROGRAM**
CALIFORNIA
1 Alturas
2 Anderson
3 Auburn
4 Banning
5 Bishop
6 Burney
7 Camp Antelope
8 Clovis
9 Covelo
10 El Cajon
11 Happy Camp
12 Hoopa
13 Lakeport
14 Lone Pine
15 Droville
16 Porterville
17 San Bernardino
18 San Jacinto
19 Santa Rosa
20 Santa Ynez
21 Santa Ysabel
22 Susanville
23 Torres-Matinez
24 Trinidad
25 Tuolumne
26 Valley Center (Pauma Valley)
27 Ukiah
28 Yreka

■ **ENVIRONMENTAL HEALTH FIELD STATIONS**
CALIFORNIA
29 Escondido
30 Eureka
31 Fresno
32 Redding

NASHVILLE AREA

▲ **HOSPITALS**
NORTH CAROLINA
1 Cherokee

△ **Tribally Operated**
MISSISSIPPI
2 Philadelphia (Choctaw)

○ **HEALTH CENTERS TRIBALLY OPERATED**
FLORIDA
3 Clewiston
4 Hollywood
5 Miami
6 Okeechobee
MAINE
7 Old Town
8 Perry
9 Princeton
NEW YORK
10 Cattaraugus
11 Hogansburg
12 Steamburg

■ **ENVIRONMENTAL HEALTH FIELD STATION**
LOUISIANA
13 Charenton

NAVAJO AREA

▲ **HOSPITALS**
ARIZONA
1 Chinle
2 Fort Defiance
3 Tuba City

△ **Tribally Operated**
ARIZONA
4 Ganado
NEW MEXICO
5 Crownpoint
6 Gallup
7 Shiprock

● **HEALTH CENTERS**
ARIZONA
8 Dilkon
9 Inscription House
10 Kayenta
11 Leupp
12 Teec Nos Pos
13 Tsaile
14 Winslow

○ **Tribally Operated**
ARIZONA
15 Rough Rock
NEW MEXICO
16 Huerfano (Dzilth-Na-D-Dithle)
17 Tohatchi

□ **SCHOOL HEALTH CENTERS**
ARIZONA
18 Many Farms
NEW MEXICO
19 Fort Wingate

OKLAHOMA CITY AREA

▲ **HOSPITALS**
OKLAHOMA
1 Ada
2 Claremore
3 Clinton
4 Lawton
5 Tahlequah

△ **Tribally Operated**
6 Okemah (Creek Nation)
7 Talihina

● **HEALTH CENTERS**
KANSAS
8 Holton
9 Lawrence
OKLAHOMA
10 Anadarko
11 Carnegie
12 Concho
13 Jay
14 Locust Grove
15 Miami
16 Pawhuska
17 Pawnee
18 Shawnee
19 Watonga
20 Wewoka
21 White Eagle

○ **Tribally Operated**
22 Ardmore
23 Broken Bow
24 Eufaula
25 Hugo
26 McAlester
27 Okmulgee
28 Sallisaw
29 Sapulpa
30 Tishomingo

PHOENIX AREA

▲ **HOSPITALS**
ARIZONA
1 Keams Canyon
2 Parker
3 Phoenix
4 Sacaton
5 San Carlos
6 Whiteriver
7 Yuma
NEVADA
8 Dwyhee
9 Schurz

● **HEALTH CENTERS**
ARIZONA
10 Bylas
11 Cibecue
12 Peach Springs
13 Second Mesa
UTAH
14 Fort Duchesne

○ **Tribally Operated**
NEVADA
15 Gardnerville (Washoe)
16 Reno-Sparks

□ **SCHOOL HEALTH CENTERS**
ARIZONA
17 Phoenix
CALIFORNIA
18 Riverside
CALIFORNIA
35 Needles
36 Riverside
NEVADA
37 Duckwater
38 Elko
39 Ely
40 Gardnerville
41 Nixon
42 Dwyhee
43 Reno
44 Yerington
UTAH
45 Cedar City
46 Salt Lake City

PORTLAND AREA

● **HEALTH CENTERS**
IDAHO
1 Fort Hall
2 Lapwai
OREGON
3 Pendleton (Umatilla)
4 Salem (Chimawa)
5 Warm Springs
WASHINGTON
6 Bellingham
7 Inchelium
8 Neah Bay
9 Nespelem
10 Taholah
11 Toppenish (Yakima)

○ **Tribally Operated**
WASHINGTON
12 Auburn (Muckleshoot)
13 La Conner (Swinomish)
14 Marysville (Tulalip)
15 Tacoma

■ **ENVIRONMENTAL HEALTH FIELD STATIONS**
WASHINGTON
16 Seattle
17 Spokane

★ OFFICE OF HEALTH PROGRAM DEVELOPMENT

▲ **HOSPITAL**
ARIZONA
1 Sells

● **HEALTH CENTERS**
ARIZONA
2 Santa Rosa
3 San Xavier (Tucson)

♦ URBAN INDIAN HEALTH PROGRAMS

ARIZONA
1 Phoenix
2 Tucson
CALIFORNIA
3 Bakersfield
4 Compton
5 Fresno
6 Sacramento
7 San Diego
8 San Francisco
9 San Jose
10 Santa Barbara
COLORADO
11 Denver
ILLINOIS
12 Chicago
KANSAS
13 Wichita
MASSACHUSETTS
14 Boston
MICHIGAN
15 Detroit
MINNESOTA
16 Minneapolis
MONTANA
17 Anaconda
18 Billings
19 Butte
20 Great Falls
21 Helena
22 Miles City
23 Missoula
NEBRASKA
24 Omaha
NEVADA
25 Reno
NEW MEXICO
26 Albuquerque
NEW YORK
27 New York City
OKLAHOMA
28 Oklahoma City
29 Tulsa
OREGON
30 Portland
SOUTH DAKOTA
31 Pierre
WASHINGTON
32 Seattle
33 Spokane
WISCONSIN
34 Green Bay
35 Milwaukee
TEXAS
36 Dallas
UTAH
37 Salt Lake City

Top—Registered pharmacists dispense from modern facilities at IHS hospitals.

Left—Tribally operated and staffed ambulances transport ill and injured persons to many IHS and contract health care facilities. Some hospitals also are equipped with helicopter landing pads and many have small aircraft landing strips nearby.

Top—Physician assistants and nurse practitioners are beneficially employed in many IHS hospitals and health centers.

Bottom—More than 60 percent of Indian Health Service employees are Indians or Alaska Natives.

Emergency medical teams in Alaska often use snow-mobiles and sleds to transport injured or ill patients to village clinics—where community health aides are in radio or telephone contact with hospital physicians.

take a leading role in reducing the causes of injuries. Community alcoholism programs also have a role in attacking the high rate of injuries among Indians and Alaska Natives.

Maternal and Child Health

A coordinated multidisciplinary approach is being promoted in IHS service delivery areas to address the comprehensive health needs of Indian and Alaska Native children, youth and the family, emphasizing services to women in child-bearing years, infants and children. Recognizing the importance of the family as the most basic unit of our society, an objective for the 1980s is to promote family centered care in all IHS facilities providing maternal and child health (MCH) services. Sensitivity to cultural beliefs and practices relating to MCH is an important component of supporting the family structure.

Health programs for infants, children and youth range from well-child surveillance to speciality programs for the developmentally disabled and chronically and acutely ill patients. The high rate of infant morbidity and post neonatal mortality is being met with emphasis on early prenatal care for the expectant mother and continued care after she and the infant leave the hospital. Health education activities provided during the anterpartum and postpartum periods assist the mother in providing caretaker and parenting skills. Health education activities provided during well-child or acute illness visits enhance the parents' knowledge of normal growth and development, how to recognize illnesses requiring medical intervention, promotion of good health habits and the benefits to be derived from regular visits to the clinic for well-child health supervision.

The goal of the health care activities for women is to provide health promotion and maintenance services relating to childbearing (obstetrics) and the reproductive cycle (gynecology) which include prevention, intervention and rehabilitative services. Family planning services to protect the health of women and promote a happy and healthy family environment are important components of the comprehensive program.

Nutrition

Promotion of optimal nutrition and nutritional care are essential components of every well-planned health program and are especially significant for quality health for Indians and Alaska Natives. For those considered at nutritional risk—infants, pre-school children, adolescents, pregnant and lactating women, the elderly and the chronically ill—sound nutrition practices are essential.

In the IHS, nutritional care is an integral part of health services delivery. Emphasis is placed on incorporating nutrition education into every available health, social and education service and food assistance program.

The nutrition and dietetics program includes preventive and direct patient care nutrition services, operation of the dietetic departments in IHS hospitals, training and career development for Indians in food service and community nutrition, advocating the improvement of the quantity and nutritional quality of the Indians' food supply and in-service education and training.

Aging

Life expectancy at birth for Indians and Alaska Natives has increased from 60.0 years during 1949-51 to 71.1 years during 1979-81. The number of American Indians 45 years or older have increased from 16.2 percent in 1960 to 18.3 percent in 1985. This has created a greater demand for health and social services for the ambulatory, home-bound and institutionalized aging persons.

The IHS, in response, is placing special attention on health assessments, with timely follow-up to prevent unnecessary illness and disability. Services are being expanded in areas of primary concern to the elderly, for example, diabetes and arthritis.

Otitis Media

Otitis Media, a disease of the middle ear, replaced tuberculosis as the Indians' major health problem prior to 1971 when the IHS Otitis Media Program was initiated with special funding from the Congress. With additional funding appropriated in 1974, the IHS established otitis media programs in each administrative area, expanded preventive efforts, increased case-finding and treatment of acute cases, intensified treatment of chronic patients and expanded rehabilitative measures.

As a result of these programs, in many areas the incidence of chronic otitis media has now been reduced to a level equal to or less than the rate observed in the national non-Indian population. At selected facilities, efforts aimed at communication disorders such as speech and language deficiencies have been undertaken along with the establishment of speciality clinics serving children with disfigured faces, learning disabilities, deafness and related health programs. Additionally, through the hearing aid program many persons of all ages have regained lost communication and social abilities.

Manpower Needs

Professionals providing comprehensive health care services include, back row from left, hospital administrator, radiologist, clinical nurse, community health nurse, construction engineer, internal medicine specialist, front row, pharmacist, X-ray technician, dental technician, sanitarian, and pediatric nurse practitioner.

Many skills are needed by the IHS to carry out its mission. The two avenues for obtaining these are recruitment and career development. Staff education, training and structured assignments for IHS employees are vehicles for improving program management, providing skills for special needs, promoting employee career development, and improving the effectiveness of consumer participation. Training opportunities are available to Indian and Alaska Native advisory health board members and tribal and corporation health program management staff and health service workers.

The IHS offers career opportunities in a wide range of professional health, allied health, administrative and other fields under the Federal Civil Service and U.S. Public Health Service Commissioned Corps personnel systems. Opportunity to choose practice sites often exists for physicians, dentists, nurses and other health professionals.

A policy for Indian preference is followed in recruitment and career development training. Currently, more than half of the IHS staff is of Indian or Alaska Native descent. Many of these, in addition to their regular duties, provide valuable interpretive, educational and motivational services.

Professional Training

Education, training and career development opportunities for IHS professional staff include speciality training in public health for physicians, dentists, nurses and others, physician residency training in pediatrics, surgery and obstetrics-gynecology, a dental residency program and a pharmacy internship. Continuing education seminars and speciality workshops for health care professionals and paraprofessionals are conducted by the staff of the Clinical Support Center in facilities at Phoenix, Arizona, at the Black Hills Training Center, Rapid City, South Dakota and at other selected locations.

Nursing Careers for Indians

One health profession in the IHS in which Indians have made notable strides in recent years is nursing. Now, approximately a fourth of the 2,260 professional nurses employed by the IHS are of Indian or Alaska Native descent. These strides have been made through the efforts of the nursing program seeking to recruit Indian nurses. The IHS also supports nursing education programs that are designed to provide Indian employees with the opportunity to obtain a degree in nursing. An IHS-supported educational program in Albuquerque, New Mexico provides for Indian licensed practical nurses to become registered nurses, with an associate or baccalaureate degree. This provides the individual and the IHS with enhanced professional skills.

COSTEP

The IHS participates in the Public Health Service Commissioned Officers Student Training Extern Program (COSTEP). The COSTEP Program offers students who are pursuing a health profession an opportunity to gain experience within the health program environment. A limited number of students are commissioned as reserve officers in the PHS Commissioned Corps and are called to active duty during free periods of their academic year. These officers may serve in any of the IHS facilities or programs. Many students who participate in

this program subsequently enter career service in the PHS.

Work-Study Programs

Work-study and cooperative education arrangements have been developed with many high schools, colleges and universities to encourage Indian students to prepare for health careers, while working in their home communities. Counseling programs also have been established to identify and place Indian students in health programs.

Allied Health Training

Allied and auxiliary health personnel of the IHS, tribes and Native corporations are vital in providing health care for Indians and Alaska Natives. By supplementing the work of health professionals, these paraprofessionals help make health services more accessible and comprehensive, strengthen continuity and increase Indian involvement in health activities.

Among the careers for which training is available are community health representative, community health aide, health records technician, dental assistant, optometric assistant, mental health worker, medical social work associate, food service supervisor and nutrition aide. On-the-job training is provided for nursing assistant, food service worker and medical records clerk.

Community Health Representative

Community Health Representative (CHR) are America Indians and Alaska Natives who are selected, employed and supervised by their tribes and communities. They are indigenous, community-based, well-trained, medically guided paraprofessional health care providers who are intensely familiar with the dialects and cultural and social uniqueness of their people. They are the fundamental access point for getting into the health care delivery system in their communities and are deeply involved in promoting health and at preventing disease. CHR provide rapid early intervention and case findings which result in the patient receiving care earlier in the course of his/her illness. For less serious cases, direct primary care and follow-up services are provided in the patient's home.

CHR learn the concepts of health and disease, basic health skills, home nursing, emergency medical services, nutrition, health education and environmental health. Principles of communication, group organization and planning as well as how to conduct meetings are also taught. Their training includes classroom study and field experience supervised by professional medical and health personnel. Almost 1500 CHR are providing services to their people residing in over 250 reservations and communities.

Community health aides in 130 Alaska villages are linked by radio and/or telephone to hospitals. These paraprofessionals give first aid, examine the ill, report symptoms to the physician and carry out recommended treatment.

Community Health Aide

The Community Health Aide Program (CHAP) was developed in Alaska to educate selected village residents to provide primary health care. Remote villages depend on the Community Health Aide (CHA) for first-line primary health care and as the initial responder for emergency care. A wide range of preventive health services provided by the CHA are coordinated with native health corporations, the States and IHS health care programs. Professional support and collaboration are provided by the physicians in various Alaska Area Native Health Service Units and Native corporation-administered hospitals. More than

400 CHA in 200 villages have been trained to provide these valuable health care services.

Medical Laboratory Technician

As part of its laboratory improvement program, the IHS conducts a 2-year program to train medical laboratory technicians for its facilities. Training is conducted at the Navajo Community College in Tsaile, Arizona, and the PHS Indian Medical Center in Gallup, New Mexico.

Dental Assistant

A 1-year program at Haskell Indian Junior College in Lawrence, Kansas, trains high school graduates to be dental assistants. Students are trained in chairside assisting, preventive services and efficient dental practice management. The training program is accredited by the American Dental Association and graduates are eligible for certification after taking the required examination.

These Indian and Alaska Native dental assistants contribute significantly to the IHS dental program, increasing dental team-provided services by more than 30 percent.

Optometric Assistant

Programs which vary in length from 3 weeks to more than a year are available at many vocational, technical and community colleges to train persons to serve as vision paraprofessionals. Optometric assistants are employed in the delivery of eye care at IHS optometry and ophthalmology clinics. These persons provide optical support and direct patient care assistance to the professionals. Where direct eye care is not available, individuals are trained as eye care coordinators to provide direct optician support for the tribe.

Mental Health Worker

The mental health worker is an essential member of the IHS health care team. These paraprofessionals are Indians or Alaska Natives who are knowledgeable about the psychological and social aspects of the people they serve. Appreciating Indian attitudes toward health and illness, such workers are highly sensitive to the needs of the communities in which they work. As such, they are instrumental in bringing about communication between the Indian patient and the non-Indian medical provider and acceptance of mental health activities by the Indian community.

Mental health workers are trained to assist psychiatrists, psychologists, psychiatric social workers and other mental health professionals in providing therapy services in the Indian community, schools, and hospitals and health centers.

Nutrition and Dietetics

Nutrition and dietetics training is provided to American Indian and Alaska Native paraprofessionals by the IHS Nutrition and Dietetics Training Program located in Santa Fe, New Mexico. The aim of the training is to upgrade skills in providing quality nutritional care by dietary personnel in Indian hospitals and by tribal employees in programs containing a nutrition component.

Tribal Leadership Training

The IHS sponsors and encourages leadership training for Indians serving on local and area health boards, the National Indian Health Board, and in other tribal capacities. Emphasis on this training has increased over the years as more Indians and Alaska Natives have become actively involved in the management of their health affairs. Training programs are conducted at the Office of Health Program Development in Tucson, Arizona, and includes management and supervision, personnel management, computer services, word processing, and other subjects needed to meet stated tribal and community needs.

IHS Manpower Program

Title I of the Indian Health care Improvement Act (P.L. 94-437) and the amendments of 1980 (P.L. 96-537) provide for the establishment of a manpower program designed to meet the needs of the IHS. The long-range objective is in Section 101.

> "The purpose of Title I is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians."

Five sections in the title support these objectives. Each provides a mechanism to accomplish the broad objectives by establishing specific programs and funding authorizations. Sections and their objectives are: 102—Health Professional Recruitment Program for Indians; 103—Health Professions Preparatory Scholarship program for Indians and Health Professions, Pregraduate scholarship program for Indians; 104—Health Professionals Scholarship Program; 105— Indian Health Extern Program; and 106—Continuing Education Allowances.

Title I also provides the legislative mandates to achieve the objective of ". . . assisting Indian tribes in developing their capacity to man and manage their health programs through activities which include health and management training."

Role of American Indians and Alaska Natives

Native artwork is purchased for newly opened IHS hospitals.

Over the past decade, tribally established community health boards, representing the tribes served by IHS have helped develop local program policy, determine needs and priorities and allocate resources. Area advisory bodies, composed of representatives of the community health boards within each IHS area, perform similar functions.

These groups are, in turn, represented by the National Indian Health Board, headquartered in Denver, Colorado, which, together with other organizations such as the National Tribal Chairmen's Association and National Congress of American Indians, work with the IHS at the national level.

Indian involvement in program implementation is equally important. From the start it was recognized that community involvement was essential to the treatment, prevention and control of unfavorable health conditions. Local community involvement has continued to expand.

Tribes and Native corporations are provided technical assistance to develop or strengthen health boards and departments, and to train staffs in administrative and management skills. This training has been expanded with the 1975 passage of the Indian Self Determination and Education Assistance Act, P.L. 93-638. Urban Indian health projects also receive IHS technical assistance.

The scope of program activities managed by tribes and Native corporations is wide. It includes community health, mental health, alcoholism and injury control services as well as activities in program planning and evaluation, and planning, construction and operation of health facilities.

Examples of Indian organizations involved in the implementation of IHS program activities are the California Rural Indian Health Board and the United South and Eastern Tribes which deliver a variety of health services in wide geographic areas.

The IHS also helps Indian and Alaska Natives to identify and seek out Federal resources applicable to their health, social and economic problems.

From the Beginnings to Today

Health services for Indians began in the early 1800's when U.S. Army physicians took steps to curb smallpox and other contagious diseases among tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide health care services were introduced in 1932 when a group of Winnebagos were promised physician care as partial payment for rights and property ceded to the Federal Government. Although most treaties imposed time limits of 5 to 20 years for the provision of health care, the Federal Government adopted a policy of continuing services after the original benefit period had expired.

The transfer of the Bureau of Indian Affairs from the War Department to the Department of Interior in 1849 stimulated the extension of physician services to Indians by emphasizing the nonmilitary aspects of Indian administration and by developing a corps of civilian field employees. Within 25 years, about half of the Indian agencies had a physician, and by 1900 the Indian Medical Service employed 83.

Nurses were added to the staff in the 1890s and their numbers grew from 8 in 1895 to 25 in 1900. Most were assigned to Indian boarding schools. Beginning in 1891, field matrons were employed to teach sanitation and hygiene, provide emergency nursing services and prescribe medicine for minor illnesses—activities which later were taken over by public health nurses.

Indian Bureau policy by the late 1800's clearly directed physicians to promote preventive activities, but efforts were limited until well after the turn of the century because the emphasis was largely curative.

The first Federal hospital built for Indians was in the 1800's in Oklahoma and a concentrated movement was underway before 1900 to establish hospitals and infirmaries on every reservation and at each boarding school. The reasons supporting the construction were the isolation in which the Indians lived, the lack of nearby facilities, and the home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

Professional medical supervision of health activities for Indians was begun in 1908 with the establishment of the position of chief medical supervisor, and was strengthened in the 1920's by the creation of the Health Division and appointment of district medical directors. The first appropriation specifically for general health service to Indians was made in 1911. The basic legislation for IHS to provide service to Indians was the Snyder Act of 1921 which authorized the expenditure of funds "for relief of distress and conservation of health of Indians throughout the United States." In 1926, medical officers of the PHS Commissioned Corps were detailed to certain positions in the program.

Individual disease control programs, such as tuberculosis, were begun early in the 1900's, and health education activities to support these programs were introduced in 1910. Dental services began in 1913 with the assignment of five itinerant dentists to visit reservations and schools. Pharmacy services were organized in 1953 with PHS pharmacy officers assigned to headquarters, area offices, and hospitals.

Until the late 1920's sanitation services did not extend beyond occasional "clean-up" campaigns and inspections of homes, schools and Indian agencies. In 1928, PHS sanitary engineers began assistance to the Bureau of Indian Affairs in surveying water and sanitation systems and investigating other problems, usually restricted to Bureau installations. An expanded program to improve sanitation in individual homes was begun in 1950.

Congress passed the Transfer Act, P.L. 83-568, in 1954. In 1955, responsibility for Indian health was transferred from the Department of Interior to the Department of Health, Education, and Welfare's Public Health Service. At the time both medical facilities and personnel were inadequate to meet the Indian's health needs.

The initial program priorities for the new PHS Division of Indian Health were 1) to assemble a competent health staff, 2) establish adequate facilities where services could be provided, 3) institute extensive curative treatment for the many Indians who were seriously ill and 4) develop and initiate a full-scale preventive program which would reduce the excessive amounts of illnesses and early deaths, especially from preventable diseases.

Health centers provide outpatient care for the entire family.

Since 1955 the Division of Indian Health, now called the Indian Health Service, has assumed more responsibilities and has expanded its staff from a small corps of health professionals to more than 9,000 skilled and dedicated men and women. The number of physicians in the program has risen from 125 to 770, dentists from 40 to 250, and registered nurses from 780 to 2,000. To its original health staff of clinical physicians and nurses, dentists, pharmacists and sanitary engineers, the program has added field health physicians, registered medical record administrators, public health nurses, registered dietitians, therapists, public health nutritionists, community health representatives aides, practical nurses, dental assistants, maternal and child health specialists, environmental sanitarians, and auxiliaries in a number of categories.

Over the past 31 years, 28 hospitals, 32 health centers and 58 health stations have built. Major alterations have been made at many facilities, and currently several are in various stages of construction. Through Public Law 85-151, 165 beds to serve Indians and Alaska Natives have been added to 20 community hospitals which were constructed with assistance from Hill-Burton Act (Title VI of the Public Health Service Act) funding.

Additionally, capabilities have been expanded through numerous educational and training activities designed to increase efficiency, augment manpower resources and promote career development.

Dramatic increases in the use of IHS services have occurred. Virtually all Indian births (99.1 percent in 1983) occur in hospitals today. Annual admissions to IHS and contract hospitals have more than doubled; outpatient visits made to hospitals, health centers and field clinics (including contract and tribal facilities) have increased 8.7 times; and the number of dental services provided is 9.6 times greater.

Many Indian tribes and intertribal organizations now are managing and operating IHS programs and services in their communities. The Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act have provisions to assist tribes desiring to assume responsibility for their health programs.

The Division of Indian Resources Liaison (IRL) located in the Office of Tribal Activities was established in 1980 (as the Indian Resource Liaison Staff) to serve as a national focal point to provide policy guidance to IHS staff, tribes, tribal/urban organizations in 1) implementing special Indian legislation and authorities; 2) formulating policies to ensure effective implementation of tribally/urban operated administrative management systems, including contracts, grants, personnel, leasing and human resource development activities; (3) developing, planning, and implementing a policy information system for dissemination to and use by tribes, tribal/urban Indian organizations, and IHS staff; and (4) coordinating the development of various policy guidance material to transmit standards and criteria, methodology, and general understanding within IHS concerning the elements of administrative systems. The IRL functions include responding to assignments and inquires about P.L. 93-638 contracts and grants, and other Indian legislation, and serving as ombudsman, and adviser to IHS staff and tribal/urban officials. Technical assistance is provided to tribes and tribal organizations and to IHS staff in identifying problems and implementing solutions to promote the Indian self-determination process.

Resource Allocation

The Indian Health Service (IHS) has been and continues to be concerned about the equitable allocation of resources for health services among the eleven Area Offices and the tribes. In response to the P.L. 94-437 National Plan and the Court decision in the case of Rincon Band of Mission Indians vs *Califano*. The Congress established an equity health care fund in FY 1981. The purpose of this fund was to insure that the tribes with the greatest level of resource deficiency receive priority funding. The IHS Resource Requirement Methodology (RRM) was the primary basis for determining the level of resource deficiency for the tribes. The level of resource deficiency was calculated on an annual basis.

The equitable distribution of resources for health services continues to be a high priority of the IHS. A major objective is the elimination of funding disparities among the eleven Area offices, service units and the tribes. The guiding principles utilized in previous resource allocation initiatives continue to be analyzed and further refined as better standards and criteria and management information become available. This initiative continues to be a cooperative effort among the tribal organizations, tribal representatives and the IHS.

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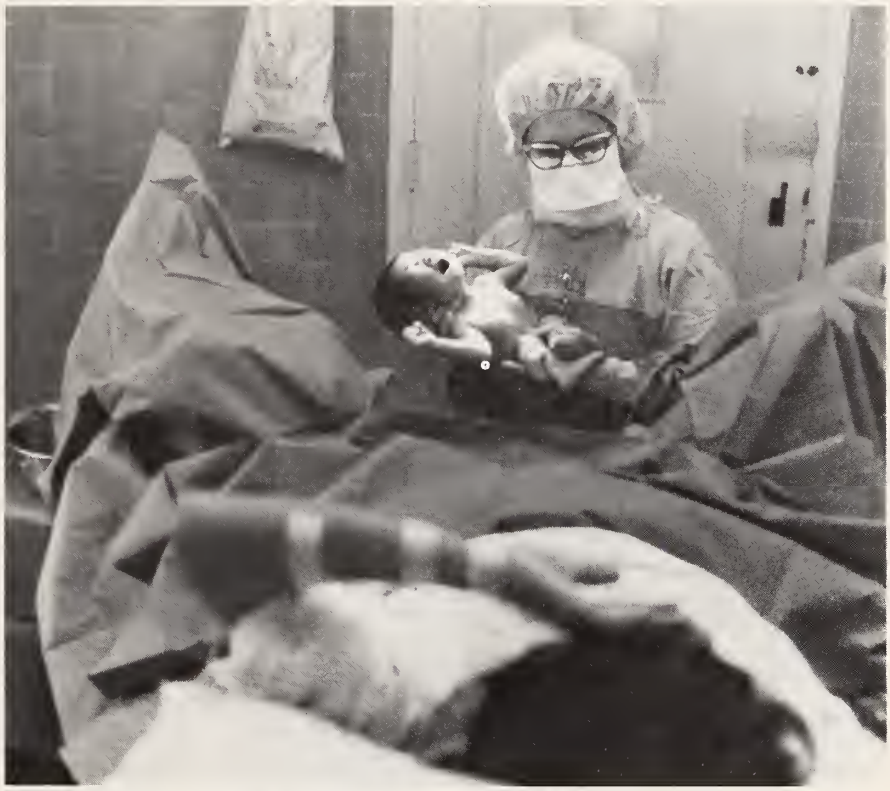
Health levels among Indians and Alaska Natives have substantially improved. From 1954-56 to the 1981-83 period, infant death rates declined from 62.7 to 11.0 per 1,000 live births; tuberculosis death rates were reduced 96 percent; gastrointestinal disease death rates are down 93 percent, and death rates from pneumonia and influenza are down 82 percent.

Tuberculosis, once the number 1 scourge of Indians and Alaska Natives, has been dramatically contained. In 1956, for example, the IHS had 3,606 such admissions to PHS Indian and contract hospitals. In fiscal year 1985, there were only 219 admissions. This represents a decline of 94 percent. New active case rates of tuberculosis also have been dramatically reduced.

There are other manifestations of better general health reflected in a leveling off of hospitalizations and an upward trend in clinic visits, signifying less severe illnesses and fewer people requiring prolonged hospital care. These changes indicate a stabilization of therapeutic health activities and the growing acceptance of health maintenance measures by Indians and Alaska Natives.



The percentage of Indian and Alaska Native babies born in hospitals has grown dramatically from 1955 to present.

Age of the Population

According to the 1980 Decennial Census, the median age of Indians and Alaska Natives residing in States served in part or in total by the IHS was 22.4 as compared with a median age of 30.0 years of U.S. population as a whole. Recent census age data indicate that there has been a slight change in the age structure of the total U.S. population. The median age of the U.S. population was estimated to be 31.2 years as of July 1, 1984. This is an increase of approximately 1.2 years over the 1980 figure. Similar changes also have occurred in the median age for Indians. A preliminary estimate for 1984 based on the increase from 1970-1980 is 23.6 years.

Vital Events

Birth Rates (Live Births Per 1,000 Population)

Indian and Alaska Native (1981-83)	28.5
U.S. All Races (1982)	15.9

Indian and Alaska Native birth rates, after steadily increasing from 1955 through 1965, have shown a downward trend. The birth rate in 1954-56 was 37.5 per 1,000 population, reaching its peak in 1959-61 with a rate of 42.1. In 1981-83 the Indian and Alaska Native birth rate was 1.8 times that for the U.S. all races.

Infant Death Rates Per 1,000 Live Births

Indian and Alaska Native (1981-83)	11.0
U.S. All Races (1982)	11.5

The Indian and Alaska Native infant death rate has declined about 82 percent since 1954-56, and is now about equal to that of the general population.

Neonatal Death Rates Per 1,000 Live Births

Indian and Alaska Native (1981-83)	5.0
U.S. All Races (1979)	7.7

The death rate among Indian and Alaska Native infants under 28 days of age has declined 70 percent since 1965-67 and is now lower than that for the general population. In 1983, 99.1 percent of In-

In Alaska, the IHS operates four hospitals.

dian and Alaska Native births occurred in hospitals. This slightly exceeds the 1980 U.S. proportion of 99.0 percent. Major causes of neonatal deaths include congenital anomalies, respiratory distress syndrome, disorders relating to short gestation and unspecified low birth weight, and newborn affected by maternal complications of pregnancy.

Post-Neonatal Death Rates Per 1,000 Live Births

Indian and Alaska Natives (1981-83)	6.1
U.S. All Races (1982)	3.8

The death rate among Indian and Alaska Native infants 28 days through 11 months of age since 1965-67 has been reduced by 82 percent, but is almost 1.6 times as high as that for the general population. In 1965-67 the Indian and Alaska Native rate (20.7) was 3 times as high as the rate for the general population in 1966 (6.5). The chief causes of post-neonatal deaths are sudden infant death syndrome (SIDS), congenital anomalies, accidents and adverse effects, meningitis, and gastroenteritis.

Leading Causes of Death (1981-1983)

Leading causes of death among Indians and Alaska Natives were diseases of the heart, accidents, malignant neoplasms, chronic liver disease and cirrhosis, cerebrovascular disease, pneumonia and influenza. These seven causes of death, which accounted for 62 percent of the total Indian and Alaska Native deaths in 1981-83, have changed little over the years. Accidents are a major cause of death with a 1983 age-adjusted death rate of 82.9 per 100,000—2.3 times that of the general population (35.3).

Use of Facilities and Services

The estimated number of Indians and Alaska Natives eligible for IHS services in 1986 is about one million. Most live on or near reservations in 32 States and in isolated villages in Alaska. Following are estimated numbers by IHS administrative areas:

Aberdeen Area (SD, ND, NB, IA)	76,000
Alaska Area (AK)	76,000
Albuquerque Area (CO and parts of NM)	54,000
Bemidji Area (MI, MN, WI)	49,000
Billings Area (MT, WY)	43,000
California Area (CA)	76,000
Nashville Area (FL., LA., ME, MS, NC, NY, PA))	37,000
Navajo Area (Parts of AZ, NM, UT)	171,000
Oklahoma City Area (OK, KS)	201,000
Phoenix Area (NV, parts of UT, AZ)	87,000
Portland Area (ID, OR, WA)	101,000
OHPD (Parts of AZ)	19,000

Direct and Contract Hospitals

The Indian Health Service operates 46 general hospitals, most of which are located in Alaska, Arizona, New Mexico, Oklahoma and South Dakota. The range of services provided includes medicine and surgery, obstetrics, tuberculosis and neuropsychiatry. The total available beds in IHS hospitals in FY 1985 numbered 2,066 (excluding bassinets). The 5 tribally-operated hospitals contain approximately 200 beds. In addition to the PHS Indian hospitals, about 1,000 beds are available through contractual arrangements with several hundred community general hospitals and State and local government tuberculosis and mental hospitals.

Illnesses Requiring Hospitalization

Illnesses and diseases for which Indian and Alaska Natives are hospitalized provide important indices for identifying health problems. Leading causes of hospitalization in FY 1985 were:

1. Complications of pregnancy, childbirth and puerperium.
2. Injuries and poisonings.
3. Respiratory systems diseases.
4. Digestive system diseases.

Distribution of Patients by Age Group

Discharges for persons under 15 years old accounted for 19 percent of the total number in 1985. This compares with 24 percent in 1975. The percentages in the other age categories have all increased since 1975.

Age Group	*1985*	*1975*
Under 15 years	19.0	23.7
15-44 years	54.2	52.2
45-64 years	15.5	15.0
65 years and older	11.3	9.1

Admissions to all hospitals including those under contract, increased about 11 percent between 1955 and 1985. Approximately 25 percent of the admissions in 1985 were to contract hospitals.

Hospital Inpatient Services

Provider	*Admissions*	*Days*
IHS Direct	74,423	381,185
IHS Contract	19,822	85,422
Tribal Direct	3,678	15,044
Tribal Contract	6,854	28,060
	108,777	509,731

Outpatient Visits 1985

IHS Outpatient hospital clinics	2,088,973
IHS health centers, field clinics, schools and other units	1,300,645
Facilities operated by tribes	667,651
To contract physicians	354,328
Total	4,411,597

Laboratories at IHS hospitals and health centers are highly automated, providing increased efficiency.

Dental Services 1985

	IHS and Tribal	*Contract a Visits*
Patients Examined	218,385	35,803
Corrective Preventive Services	1,615,966	252,090

Eye Care Program 1985

Eye Examinations	82,036

The Eye Care Program consists of optometrists, opthalmologist technicians, supplemented by a number of optometry community health representatives. The majority of the primary eye care services are provided by optometrist who diagnose and treat a number of ocular and vision problems. Additional surgical, consultative and other services are provided by opthalmologist in the larger medical facilities. There are presently (1986) 45 optometrist and 10 opthalmologist who are direct IHS providers. Vision screenings, ocular diabetes program, and vision safety programs complement other specialty services provided throughout IHS and tribal facilities.

The statistics of representative facilities are given to provide a suggestion of the relative size of the facility.

Location	No. of Beds	Outpatient Visits 1985
Alaska		
Anchorage	170	99,677
Barrow	14	17,793
Bethel	50	49,710
Bristol Bay (Dillingham)**	28	12,056
Kotzebue	27	19,251
Mt. Edgecumbe**	78	16,938
Norton Sound (Nome)**		17,948
Arizona		
Chinle	52	65,102
Ft. Defiance	68	70,638
Ft. Yuma	17	18,375
Keams Canyon	26	30,425
Parker	20	21,115
Phoenix	167	94,740
Sacaton	20	39,887
San Carlos	28	34,952
Sells	40	37,597
Tuba City	101	97,850
Whiteriver	44	49,613

The Phoenix Indian Medical Center has 163 operating beds.

Location	No. of Beds	Outpatient Visits 1985
Minnesota		
Cass Lake	22	28,582
Red Lake	23	40,266
Mississippi		
Choctaw (Philadelphia)**	40	24,856
Montana		
Browning	34	52,891
Crow Agency	34	34,130
Harlem	18	20,180
Nebraska		
Winnebago	38	26,794
Nevada		
Owyhee	15	11,990
Schurz	14	8,997
New Mexico		
Acoma-Canoncito-Laguna	40	26,849
Albuquerque	54	52,342
Crownpoint	28	33,003
Gallup	116	124,850
Mescalero	15	20,344
Santa Fe	55	33,910
Shiprock	50	100,333
Zuni	45	33,067

Location	No. of Beds	Outpatient Visits 1985
North Carolina		
Cherokee	35	50,291
North Dakota		
Belcourt	46	60,243
Ft. Yates	32	25,262
Oklahoma		
Ada	53	54,606
Claremore	60	94,661
Clinton	14	19,250
Creek Nation**		5,002
Lawton	52	47,636
Tahlequah	60	118,011
Talihina**	50	20,771
South Dakota		
Eagle Butte	11	27,113
Pine Ridge	58	49,410
Rapid City	39	34,713
Rosebud	29	45,576
Sisseton	20	19,200
Wagner	26	22,636
Totals		
Hospitals		51
Beds Available		2,066
Outpatient Visits-1985		2,161,432

**Tribally Operated

IHS Health Centers

The following are the larger representative health centers.

Location	Visits in 1985
Alaska	
Fairbanks**	22,144
Ft. Yukon**	4,090
Juneau**	18,241
Ketchikan	15,907
Metlakatla	8,967
St. Paul	3,570
St. George**	490
Tanana**	2,863
Arizona	
Cibecue	7,871
Dilkon	3,909
Inscription House	17,694
Kayenta	35,502
Leupp*	467
Many Farms*	4,073
Peach Springs	9,848
Phoenix*	4,324
Rough Rock**	2,364
Santa Rosa	8,053
San Xavier	14,255
Teec Nos Pos	6,250
Tsaile	13,575
Winslow	24,797
California	
Anderson**	5,994
Auburn**	3,450
Banning**	12,155
Bishop**	11,768
Clovis**	9,180
Covelo**	3,852
El Cajon**	5,730
Hupa**	9,897
Oroville**	5,244
Pauma Valley**	4,839
Porterville**	4,485
San Bernardino**	5,721
San Jacinto**	5,160
Santa Rosa**	8,175
Trinidad**	11,868
Tuolumne**	1,449
Ukiah**	5,154
Colorado	
Ignacio	10,738
Towaoc	9,897
Florida	
Big Cypress**	3,922
Brighton**	3,958
Hollywood**	5,023
Miccosukee	2,669
Idaho	
Fort Hall	30,803
Northern Idaho (Lapwai)	14,591
Kansas	
Haskell	11,455
Holton	7,603
Maine	
Pleasant Point**	6,354
Peter Dana Point**	7,291
Indian Island**	4,072
Michigan	
Kincheloe	17,717
Minnesota	
White Earth	18,212
Nin-No-Yah-Win**	3,794
Montana	
Lame Deer	36,055
Lodge Grass	13,770
Poplar	34,556
Rocky Boy's	18,447
St. Ignatius	2,937
Wolf Point	16,257
Nebraska	
Carl T. Curtis**	19,729
Nevada	
Reno Sparks**	7,929
Washoe**	4,622
New Mexico	
Dulce	18,464
Dzilth-Na-O-Dith-le	6,251
Ft. Wingate	2,413
Isleta	14,660
Jemez	9,870
Laguna	11,042
Pine Hill	13,031
Southwestern Poly-Tech Institute*	947
Santa Clara	10,553
Taos	7,287
Tohatchi	13,289
New York	
Allegany**	7,943
Cattaraugus**	16,228
St Regis Mohawk**	14,279
North Dakota	
Ft. Totten	19,532
Minni Tohe (New Town)	12,471
Trenton-Williston**	1,678
Wahpeton*	5,994
Oklahoma	
Anadarko	27,544
Carnegie	7,264
Concho	5,969
Eufaula**	15,524
Jay**	16,306
Hugo**	9,430
Broken Bow**	10,660
D.K. Martin**	16,924
McAlester**	8,420
Miami	16,306
Okemah**	12,015
Pawhuska	16,046
Pawnee	14,608
Sallisaw**	11,349
Sapulpa**	12,794
Shawnee	42,786
Tishomingo**	10,925
Watonga	6,826
Wewoka	24,080
White Eagle	18,906
Oregon	
Chemawa	13,616
Warm Springs	22,129
Yellowhawk	12,471
South Dakota	
Flandreau*	10,022
McLaughlin	7,579
Pierre*	3,742
Wanblee	6,081
Utah	
Ft. Duchesne	11,848
Washington	
Colville	19,277
Inchelium	5,692
Lummi	20,001
Muckleshoot**	3,724
Neah Bay	11,438
Puyallup**	20,180
Taholah	10,894
Tulalip**	3,633
Wellpinit	11,835
Yakima	41,969
Wisconsin	
Chippewa**	16,285
Chequamegon Bay**	2,328
Menominee**	29,039
Oneida**	25,063
Lac Courte Oreilles**	10,406
Stockbridge-Munsee**	12,575
Wyoming	
Arapahoe	20,812
Ft. Washakie	29,807
Totals	
Health Centers	132
Visits in 1985	1,563,253

*School Health Center
**Tribally Operated

Indian Health Service
Administrative Offices

Headquarters

- Indian Health Service
  Parklawn Building, Rm. 5A-55
  5600 Fishers Lane
  Rockville, Maryland 20857
  (301) 443-1083
- Headquarters West - Albuquerque
  Indian Health Service
  2401 12th Street, N.W. Room 316
  Albuquerque, New Mexico 87102
  (505) 766-5557
- Office of Health Program
  Development
  Indian Health Service
  7900 So. J J Stock Rd
  Tucson, Arizona 85746-9352
  (602) 629-6600

Areas

- Aberdeen Area
  Indian Health Service
  Federal Building
  115 4th Avenue, S.E.
  Aberdeen, South Dakota 57401
  (605) 225-0250
- Alaska Area
  Native Indian Health Service
  P.O. Box 7-741
  Anchorage, Alaska 99510
  (907) 265-9153
- Albuquerque Area
  Indian Health Service
  505 Marquette Ave. N.W.
  Suite 1500
  Albuquerque, NM 87102
  (505) 766-2151
- Bemidji Area
  Indian Health Service
  Box 489
  203 Federal Building
  Bemidji, Minnesota 56601
  (218) 751-7701
- Billings Area
  Indian Health Service
  P.O. Box 2143
  711 Central Avenue
  Billings, Montana 59103
  (406) 657-6403
- California Area
  Indian Health Service
  2999 Fulton Avenue
  Sacramento, California 95821
  (916) 978-4202
- Nashville Area
  Indian Health Service
  Oaks Tower Building, Suite 810
  1101 Kermit Drive
  Nashville, Tennessee 37217
  (615) 736-5104
- Navajo Area
  Indian Health Service
  P.O. Box G
  Window Rock, Arizona 86515
  (602) 871-5811
- Oklahoma City Area
  Indian Health Service
  215 Dean A. McGee Street, N.W.
  Oklahoma City, Oklahoma 73102-3477
  (405) 231-4796
- Phoenix Area
  Indian Health Service
  3738 N. 16th Street, Suite A
  Phoenix, Arizona 85016
  (602) 241-2052
- Portland Area
  Indian Health Service
  Federal Building, Room 476
  1220 S.W. 3rd Avenue
  Portland, Oregon 97204
  (503) 221-2020

IHS